Health and Human Services Commission
Hospital Payment Advisory Committee (HPAC)

Department of Aging and Disabilities Services Complex
John H. Winters Building, Public Hearing Room
701 W. 51st, Austin, TX

Meeting Minutes
February 11, 2016

Members Present:	**Members Absent:**
William Galinsky, Chair	Stephen Kimmel
Timothy McVey, Vice Chair	Eric Hamon
Phillip Caron	
Steven Hand	
Alec King	
Rebecca McCain	
Diana Strupp	
Michael Nunez	
Bill Bedwell	

1. **Opening Comments, Introduction of New Members – William Galinsky, Hospital Payment Advisory Committee Chair**

   Mr. Galinsky called the meeting to order at 1:30 pm and based upon the members in attendance, a quorum was present. Mr. Galinsky introduced the new HPAC member Steve Hand. Steve Hand then briefly stated he works with Memorial Hermann and he has been attending the HPAC meetings for over 10 years; however, this is his first time as a committee member. Dr. Galinsky announced another opening on HPAC due to a resignation. Pam McDonald was introduced as sitting in for Gary Young.

2. **Approval of February 12, 2015 meeting minutes**

   Rebecca McCain moved for approval.
   Diana Strupp and Michael Nunez - seconded the motion.
   The motion to approve the minutes passed unanimously.

NOTICE OF INFORMATIONAL ITEM:

3. **Potentially Preventable Readmissions and Potentially Preventable Complications.**

   The Health and Human Services Commission (HHSC) proposes to amend the Texas Administrative Code, Title 1, Part 15, Chapter 354, Subchapter A, Division 35, §354.1445 (relating to Potentially Preventable Readmissions) and §354.1446 (relating to Potentially Preventable Complications). The rules are being amended for two reasons. The first is to outline the ability of a hospital to request its underlying data used in the analysis that determines

penalties and incentive payments. The proposed amendments specify the additional information a hospital can expect in the underlying data, including readmission data on other hospitals.

The second reason is to identify a methodology for incentives for HHSC-defined safety-net hospitals. This is pursuant to House Bill 1, 84th Legislature, Regular Session, 2015 (Article II, Special Provisions Section 59(b)), which directs HHSC to provide incentive payments to safety-net hospitals in the amount of $150,378,593 (all funds) in fiscal year 2016 and $148,641,716 (all funds) in fiscal year 2017. It specifies HHSC establish a program to use ten percent of these additionally appropriated funds to distribute to these hospitals based on quality metrics. Total reimbursement for each hospital must not exceed its hospital specific limit. However, HHSC will expend ten percent of these funds to provide additional increases to safety-net hospitals above which exceed existing quality metrics, which may result in exceeding the hospital specific limit. To the extent possible, HHSC will ensure that any funds included in Medicaid managed care capitation rates are distributed by the managed care organizations to the hospitals.

- *Matt Ferrara, Director, HHSC Health Policy & Clinical*

Committee members had several questions about this rule item.

Diana Strupp asked the committee be given some idea of how many hospitals were in the initial base pool for qualifying for this incentive payment and then based upon the rule and the way it is written, how many would ultimately qualify for the incentive payments. Mr. Ferrara responded **t**he total universe of hospitals was approximately 85 to 90 in terms of safety net eligible hospitals. The first run indicated about 26 hospitals eligible for the PPCs and about 15 for the PPRs being eligible.

The question was asked how the incentive will be paid; whether a part of the SDA or lump sum. Mr. Ferrara stated as part of the calculations, the in-patient paid claims for the hospital and the percentage of the in-patient paid claims that are paid in fee-for-service versus through a managed care arrangement were reviewed; the same percentage is being allocated for payment. Thus, if a hospital were to get $1 million in incentive and 40% of their claiming for the period being reviewed was fee-for-service, $400,000.00 would be paid out through fee for service via a lump sum payment. The remaining 60% would be paid out through the MCO cap by MCOs.

Tim McVey asked that Mr. Ferrara confirm his understanding of the rule that if a hospital fails on PPRs, then it is over the threshold and not eligible for the PPC incentive payment. Mr. McVey asked what the rationale was behind that logic. Mr. Ferrara responded the rationale was with a relatively small amount of funds there needed to be a relatively narrow pool of hospitals so the hospitals would receive a meaningful amount of money. HHSC was also operating under the assumption that having consistency in performance on those two metrics would send a consistent signal in terms of rewards.

Tim McVey asked Matt Ferrara whether he is of the opinion there is no connection between the socio-economic status of patients cared for by a hospital and the PPR rate. HHSC has reviewed the PPR data in terms of how it impacts different groupings of hospitals and as of

their last review weren't seeing any patterns in adverse impact in different kinds of groups of hospitals.

Tim McVey questioned if HHSC is using preliminary information. Mr. Ferrara responded the analysis was done for fiscal year 2013 claims data. He presented that HHSC is working on stratifying the data on PPCs and PPRs by different types of hospitals; psychiatric, children's, teaching hospitals, rural, urban, after having initially reviewed teaching hospitals, and intends to review in depth to determine if there is bias in the performance against the other types of hospitals. Tim McVey stated he did take exception to the PPR component, and he believes socio-economic status of the community makes a difference. Mr. McVey perceived the intent of the legislation is to help safety net hospitals, and ends up reallocating it to hospitals that perhaps don't have as hard of a time hitting these PPRs. Mr. Ferrara responded that HHSC conducted a 2013 review of the PPRs in areas where income levels were in different stratifications and was not able to see a pattern that impacted any of the different groupings.

Steve Hand stated his understanding was that there were fifteen hospitals that qualified under the PPR and twenty six that made it under the PPC. He questioned Mr. Ferrara as to whether he used bad math in his calculations that there were fifteen that made the first cut and there were an additional eleven that are to be paid on it under the PPCs; he observed the group of twenty six will include 100% of those that are in the fifteen group as they could not get a PPC payment if they were not getting a PPR payment. Mr. Ferrara stated that a hospital could not get a PPC payment if they were penalized on the PPR payment.

Phil Caron asked if HHSC already has a Microsoft Excel model built, can it be shared with the association and with the rest of the industry. Mr. Ferrara replied that HHSC has done that with the associations, assisting them at their computers and talking through column by column.

Diana Strupp stated the threshold in the first year of the incentive payment outlines the hospital has to be below .91; she feels this is very restrictive and doesn't give the State a lot of room in out years to increase quality. Ms. Strupp proposed that in the first year a hospital that doesn't have a PPR and is a safety net hospital, could be put into a pool without a threshold, as long as they don't receive a penalty for going below the 1.099. Mr. Ferrara observed that this argues for more flexibility in the rule and that a requirement of a rule is that it be relatively concrete in metrics and thresholds. Diana Strupp asked how the .91 was developed. Mr. Ferrara answered that HHSC looked at the reimbursement reduction scheme being 10% above, and at the inverse or the mirror of that for the incentive, 10% above being when reimbursement reductions begin to occur. HHSC determined that 10% below would be the point at which an incentive would be applied.

Bill Bedwell recommended making the data more transparent for hospitals requesting the data, also to add patient billing numbers. He encouraged hospitals to look at their data more frequently. Mr. Bedwell recommended a quicker turnaround and a method for reporting, particularly on readmissions.

Steve Hand asked if Mr. Ferrara is at liberty today to discuss what items are being put into the file to assist hospitals with matching. Mr. Ferrara confirmed that Mr. Hand was referring to the underlying data the hospitals request and then responded that items being put into the file include data elements such as the Medicaid patient number, the claim number, the admission date, the discharge date; for PPCs, each PPC is listed. Mr. Ferrara responded that if the data field exists, and the data comes across as a claim, HHSC can provide the information. He asked the hospitals communicate with HHSC what is needed to link data to hospital systems in order to do quality improvement.

Bill Galinsky asked if the changes will be available for all of the hospitals. Mr. Ferrara responded that if the fields of information exist it will be available for all hospitals.

Diana Strupp observed HHSC used one year for preliminary assessment of the 85 total hospitals and asked if HHSC considered adding an additional year to determine how the base might change and consequently how the number of qualifying hospitals would change. Mr. Ferrara responded HHSC was operating under the assumption it would use the same period as used with reimbursement reductions. Argument might be made for future rule revision to assure that accommodations are made; however, for the present, a pool of sufficient performers exists that meet the threshold.

Tim McVey asked for clarification of the low volume threshold. Mr. Ferrara stated it is 40 admissions at risk for PPR or PPC and at least 5 PPC stays or 5 actual or expected PPR chains . With the low volume threshold, anything below that is considered to be a volatile measurement and as such are excluded from reimbursement reductions.

Bill Galinsky asked about the number of hospitals that ended up being eligible. Mr. Ferrara responded the PPC number may change, but at last review there were approximately 26 that were eligible, and 15 eligible for PPRs. Bill Galinsky observed of the one hundred and fifty million dollars the legislature put up for safety net hospitals, 10% of that amount is taken for this program. He questioned if the 10% sum is only being distributed to 76 hospitals, what happens to the hospitals that didn't make the cut. Mr. Ferrara responded if a hospital is low volume, it is excluded from a reimbursement reduction and it is also excluded from being eligible for an incentive. Mr. Galinsky questioned if any of the 10% that was set aside for the program is available for low volume hospitals. Mr. Ferrara responded the 10% being used is for the total universe of 85 hospitals; the limiting criteria would establish the pool of hospitals for both PPC and PPR. Mr. Ferrara clarified the reimbursement reduction is separate; it is just the incentive payment and 10% of that money is for the purpose of rewarding high performers. Bill Galinsky questioned if the 10% above the average and the 10% below the average is it the average of the safety net hospitals or is it the average of all hospitals in the program in Medicaid in the state of Texas. Mr. Ferrara responded it is the average of all hospitals in the state. Mr. Galinsky stated if it is recognized that safety net hospitals have a bigger burden trying to meet the standards because of socioeconomic differences, going with the average from the entire State makes it an even higher hill for them to climb. Mr. Ferrara stated that HHSC is being consistent in the logic the average of all hospitals in Texas is being used for reimbursement reductions; it is being done on both sides of the equation.

Testimony:

Maureen Milligan, President/CEO, Teaching Hospitals of Texas (THOT), testified as neutral to the rule. She offered instead of looking at claims based measures, maybe we should focus on outcome measures.

Updates on Waiver 2.0, DSHS, Medicaid Re-enrollment and SB200 were presented by HHSC staff as requested by Bill Galinsky.

4. Public Comment - No Additional public comment was received.

5. Mr. Galinsky announced the next meeting is set for Thursday, May 05, 2016, at 1:30 pm.

6. There being no further business, Mr. Galinsky adjourned t he meeting.